

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

10189-62-040127
STATE FILE NUMBERDO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

FILED NOV 1 1962

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH

a. COUNTY

St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis

Length of stay in 1b

4 Hrs.

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTE

Barnes Hospital

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Illinois b. COUNTY Madison

c. CITY OR TOWN Granite City

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

4724 Nameoki Rd.

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First Middle Last
Charles Andrew Cross4. DATE OF DEATH Month Day Year
Oct. 23, 1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

8-12-17

9. AGE (last birthday)

45

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Motor Grader Operator

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (City and state or country)

Virgennes, Ill.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Willis A. Cross

13b. MOTHER'S MAIDEN NAME

Carrie Robinson

14. NAME OF HUSBAND OR WIFE

Gertrude

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

W. A. Cross - R-3 - Murphysboro

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

2 days

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Oct 22 to Oct 23 and last saw her him alive on Oct 23 1:00 PM
Death occurred at Oct 23 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Leonard R. Davis
Davis Funeral Home 21st & Cleveland

OCT 24 1962

Earl Smith, M.D.

USE BLACK INK

OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Leonard R. Davis

Licensed Embalmer No. 8375

P. O. Address Granite City, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.